MCBS MAIN STUDY - ROUND 34, FALL 2002

COMMUNITY COMPONENT

HI. HEALTH INSURANCE

BOX HIS1A	IF THIS IS SP'S EXIT INTERVIEW AND PREVIOUS INTERVIEW NOT SKIPPED, GO TO ***BOX DM1***. OTHERWISE, GO TO ***BOX HIS4A*** IF NO PREVIOUS HEALTH INSURANCE DATA (INTTYPE = 3) OR GO TO HISINTRO IF PREVIOUS HEALTH INSURANCE DATA.

HISINTRO. Now I'd like to review with you the information we have about health insurance plans that (you/SP) had at the time of the last interview.
[HAND HEALTH INSURANCE SUMMARY PAGE TO R.]
[PRESS ENTER TO CONTINUE.]

HIS1. [Let's see if there are any other changes we need to make to the health insurance coverage (you/SP) had as of (PREVIOUS ROUND INTERVIEW DATE).] [(You/SP) had Medicare coverage (through a managed care plan) and (you were/he was/she was) also covered by [READ PLAN NAMES BELOW]/The only health insurance coverage (you/SP) had was Medicare (through a managed care plan)] on (PREVIOUS ROUND INTERVIEW DATE). Is that correct?

YES, ALL CORRECT AS SHOWN	1	(HISCLOSE)
NO, PLAN MISSING	2	(HIS3)
NO, PLAN NAME INCORRECT	3	(HIS2)
NO, PLAN NEEDS DELETION	4	(HIS2)
DON'T KNOW	-8	(HISCLOSE)

HIS2. [What is the name of the plan that (is incorrect/needs deletion)?]

BOX HIS1	IF HIS1 = 4 (PLAN DELETED), GO TO HIS2a. OTHERWISE, GO TO HIS1.

HIS2a. INTERVIEWER: BRIEFLY EXPLAIN WHY (PLAN NEEDS/PLANS NEED) DELETION.

PLANDVB1 _____

PLANDVB2 _____

PLANDVB3 _____

PLANDVB4 _____

OMB # 0938-0568
Exp. 4/30/04

HIS3. [What type of insurance plan needs to be added?]

MEDICAID/MEDICAID MANAGED CARE PLAN	1	***BOX HIS2***
PUBLIC PLAN OTHER THAN MEDICAID	2	***BOX HIS2***
PRIVATE HEALTH INSURANCE PLAN	3	***BOX HIS2***
MEDICARE MANAGED CARE PLAN	4	***BOX HIS2***

BOX HIS2	IF 1, ASK HIS6 – HIS10c, THEN RETURN TO HIS1. IF 2, ASK HIS12 – ***BOX HIS3***, THEN RETURN TO HIS1. IF 3, ASK HIS20 – HIS33c, THEN RETURN TO HIS1. IF 4, ASK HISMC1 – HISMC14, THEN RETURN TO HIS1.

HISMC1. What is the name of the Medicare Managed Care Plan that covered (you/SP)?
[ENTER ONLY ONE PLAN.]

HISMC2. (Were you/Was SP) covered by or enrolled in (HISMC1 PLAN NAME) on (PREVIOUS ROUND INTERVIEW DATE)?

YES	1	***BOX HISMC1***
NO	2	***BOX HISMC2***
REFUSED	-7	***BOX HISMC2***
DON'T KNOW	-8	***BOX HISMC2***

BOX HISMC1	IF NO OTHER MEDICARE MANAGED CARE PLAN IS CURRENT, GO TO HISMC4. OTHERWISE, GO TO HISMC3.

HISMC3. I recorded previously that (CURRENT MEDICARE MANAGED CARE PLAN NAME) was (your/SP's) current Medicare Managed Care Plan on (PREVIOUS ROUND INTERVIEW DATE). Has this information changed?

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HISMC2	IF HISMC2 OR HISMC3 = 2, REF OR DK, THEN MARK PLAN ADDED/SELECTED AT HISMC1 AS "STOPPED" AND RETURN TO HIS1. OTHERWISE, GO TO HISMC4.

HISMC4. Did (you/SP) have prescribed medicine coverage through (HISMC1 PLAN NAME)?

[PROBE: I am asking about the type of insurance coverage that (you/SP personally had), not what the plan offers everyone.]

MHMORX

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HISMC5. Did (you/SP) have dental coverage through (HISMC1 PLAN NAME)?

MHMODENT

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HISMC6. Did (you/SP) have optical coverage through (HISMC1 PLAN NAME), that is, for eyeglasses or contact lenses?

MHMOEYE

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HISMC7. Did (you/SP) have coverage for preventive care such as routine annual physicals through (HISMC1 PLAN NAME)?

MHMOPCAR

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HISMC8. Did (your/SP's) (HISMC1 PLAN NAME) coverage include nursing home care over and beyond what Medicare normally covers?

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. In 2002, the first 20 days are paid in full and the next 80 days require a copayment of up to $101.50 per day.]

MHMONH

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HISMC9. Besides the cost of (your/SP's) Medicare Part B premium, was there an additional cost for (your/SP's) (HISMC1 PLAN NAME) coverage? Please do not include any amount that (you/SP) may have paid as a co-payment for an office visit or a prescribed medicine.

[EXPLAIN IF NECESSARY: Some managed care plans may charge a monthly premium to cover the cost of the deductibles and coinsurance for normal Medicare services or because they provide services that are not covered by Medicare such as prescribed medicines, routine exams, and dental, eye, or hearing. Plans that have premiums typically charge from $50 to $75 per month.]

MHMOPAY	YES	1	(HISMC10)
	NO	2	(HISMC13)
	REFUSED	-7	(HISMC13)
	DON'T KNOW	-8	(HISMC13)

HISMC10. Not including the cost of (your/SP's) Medicare Part B premium, what was the <u>additional</u> amount that [you/(SP)] paid for (your/his/her) (HISMC1 PLAN NAME) coverage? [Please do not include any copayments (or any amount that may be paid for (your/SP's) spouse's coverage).]

[PROBE IF NECESSARY: Was that per year, per month, per week, or what?]

AMOUNT $ _____.____

MHMOAMT	PER YEAR	1
MHMOUNIT	QUARTERLY/EVERY 3 MONTHS	2
MHMOUNOS	BIMONTHLY/EVERY 2 MONTHS	3
	PER MONTH	4
	PER WEEK	5
	SEMI-ANNUALLY/2 TIMES PER YEAR	6
	SEMI-MONTHLY/2 TIMES PER MONTH	7
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HISMC11. Did anyone else, such as an employer, a union or professional organization pay all or some portion of the additional cost for (your/SP's) (HISMC1 PLAN NAME) coverage?

MHMOCOST	YES	1	(HISMC12)
	NO	2	(HISMC13)
	REFUSED	-7	(HISMC13)
	DON'T KNOW	-8	(HISMC13)

HISMC12. Who else paid all or some portion of the additional cost for (your/SP's) (HISMC1 PLAN NAME) coverage?

	(SP's) CURRENT EMPLOYER	1
	(SP's) FORMER EMPLOYER	2
	(SP's) UNION	3
MHMOWHO	SPOUSE'S CURRENT EMPLOYER	4
	SPOUSE'S FORMER EMPLOYER	5
	PROFESSIONAL/FRATERNAL ORGANIZATION	6
MHMOWHOS	MEDICAID/MEDICAL ASSISTANCE	7
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HISMC13. What is the most important reason (you/SP) decided to become a member of (HISMC1 PLAN NAME)?

SHOW CARD HIMC2A

MHMOMEMB **MHMOMEOS**	LOWER COST	1
	BETTER BENEFITS OR COVERAGE	2
	DOCTOR WAS MEMBER	3
	CONVENIENT LOCATION	4
	RECOMMENDATION OR REPUTATION	5
	SP's CURRENT/FORMER EMPLOYER PAYS PREMIUM	6
	SPOUSE'S CURRENT/FORMER EMPLOYER PAYS PREMIUM	7
	LESS PAPERWORK	8
	PREVIOUS MANAGED CARE PLAN NAME CHANGED OR WAS BOUGHT BY/ MERGED WITH CURRENT PLAN	9
	BETTER SELECTION OF PROVIDERS	10
	BETTER QUALITY OF CARE	11
	COULDN'T GET MEDICARE SUPPLEMENTAL INSURANCE (MEDIGAP)	12
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HISMC14. Some Medicare Managed Care Plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. [Were you/Was (SP)] enrolled in a point-of-service option?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a $10 copayment. However, the member may have to pay 20 percent of the cost and the managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

MHMOPOS	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

HIS3a. OMITTED IN ROUND 23.

HIS4 AND HIS5 OMITTED.

HIS6. (Were you/Was SP) covered by MEDICAID the whole time between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), or only part of the time?

COVTIME	THE WHOLE TIME	1	(HIS10a)
	PART OF THE TIME	2	(HIS7)
	REFUSED	-7	(HIS10a)
	DON'T KNOW	-8	(HIS7)

HIS7. (Were you/Was SP) covered by MEDICAID on (PREVIOUS ROUND INTERVIEW DATE)?

COVNOW	YES	1	(HIS8)
	NO	2	(HIS9)
	REFUSED	-7	(HIS10a)
	DON'T KNOW	-8	(HIS10a)

HIS8. On what date did (your/SP's) MEDICAID start between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)?

COVBEGMM	_____/_____/_____			(HIS10a)
COVBEGDD	MM	DD	YY	
COVBEGYY				

HIS9. On what date between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE) did (your/SP's) MEDICAID coverage stop?

COVENDMM	_____/_____/_____			(HIS10a)
COVENDDD	MM	DD	YY	
COVENDYY				

HIS10. OMITTED IN ROUND 30.

HIS10a. Some states now use managed care plans, such as HMOs (health maintenance organizations), to provide some or all health care for Medicaid beneficiaries. (Were you/Was SP) enrolled in a Medicaid Managed Care Plan on [(PREVIOUS ROUND INTERVIEW DATE)/(MEDICAID COVERAGE STOP DATE)/the date (your/SP's) Medicaid coverage stopped]?

MCAIDHMO	YES	1	(HIS10b)
	NO	2	(HIS10c)
	REFUSED	-7	(HIS10c)
	DON'T KNOW	-8	(HIS10c)

HIS10b. As far as you can recall, (were you/was SP) given a choice to enroll in a Medicaid Managed Care Plan, or did (you/he/she) have to enroll to receive Medicaid benefits?

CHOICHMO

GIVEN A CHOICE TO ENROLL	1	
HAD TO ENROLL	2	
DOESN'T REMEMBER	3	
REFUSED	-7	
DON'T KNOW	-8	

HIS10c. Did [your/(SP's)] Medicaid plan cover medicines prescribed by a doctor?

MCDRXCOV

YES	1	(HIS1)
NO	2	(HIS1)
REFUSED	-7	(HIS1)
DON'T KNOW	-8	(HIS1)

HIS11 OMITTED.

HIS12. What is the name of the public program that covered (you/SP)?
[ENTER ALL PUBLIC PROGRAMS.]
PLNAME

HIS13. (Were you/Was SP) covered by (HIS12 PUBLIC PLAN NAME) the whole time between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), or only part of the time?

COVTIME

THE WHOLE TIME	1	(HIS16a)
PART OF THE TIME	2	(HIS14)
REFUSED	-7	(HIS16a)
DON'T KNOW	-8	(HIS14)

HIS14. (Were you/Was SP) covered by (HIS12 PUBLIC PLAN NAME) on (PREVIOUS ROUND INTERVIEW DATE)?

COVNOW

YES	1	(HIS15)
NO	2	(HIS16)
REFUSED	-7	(HIS16a)
DON'T KNOW	-8	(HIS16a)

HIS15. On what date did (your/SP's) (HIS12 PUBLIC PLAN NAME) coverage start between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)?

COVBEGMM _____/_____/_____ (HIS16a)
COVBEGDD MM DD YY
COVBEGYY

HIS16. On what date between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE) did (your/SP's) (HIS12 PUBLIC PLAN NAME) coverage stop?

COVENDMM _____/_____/_____
COVENDDD MM DD YY
COVENDYY

HIS16a. Did [your/(SP's)] (HIS12 PUBLIC PLAN NAME) plan cover medicines prescribed by a doctor?

PUBRXCOV

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIS17/HIS18 OMITTED.

BOX HIS3	GO TO HIS13 FOR NEXT PUBLIC PLAN ADDED AT HIS12. IF NO OTHER PUBLIC PLAN, THEN GO TO HIS1.

HIS20. What is the name of each of the (other) private plans that provided (your/SP's) medical insurance coverage between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)? [ENTER ALL PRIVATE PLANS.]
PLNAME
PLANSUMM

HIS21. (Were you/Was SP) covered by (HIS20 PLAN NAME) the whole time between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), or only part of the time?

COVTIME

THE WHOLE TIME	1	(HIS25)
PART OF THE TIME	2	(HIS22)
REFUSED	-7	(HIS25)
DON'T KNOW	-8	(HIS22)

HIS22. (Were you/Was SP) covered by (HIS20 PLAN NAME) on (PREVIOUS ROUND INTERVIEW DATE)?

COVNOW

YES	1	(HIS23)
NO	2	(HIS24)
REFUSED	-7	(HIS25)
DON'T KNOW	-8	(HIS25)

HIS23. On what date did (your/SP's) coverage under (HIS20 PLAN NAME) start between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)?

COVBEGMM _____/_____/_____ (HIS25)
COVBEGDD MM DD YY
COVBEGYY

HIS24. On what date between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE) did (your/SP's) coverage under (HIS20 PLAN NAME) stop?

COVENDMM _____/_____/_____
COVENDDD MM DD YY
COVENDYY

HIS25. [CODE WITHOUT ASKING IF VOLUNTEERED.]
Was this a managed care plan, such as an HMO (Health Maintenance Organization)?
[EXPLAIN IF NECESSARY: Managed care plans generally provide a full range of health care services for a prepaid fee. The major types of managed care plans are health maintenance organizations (HMOs), HMOs with a point-of-service option, Provider-Sponsored Organizations (PSOs) and Preferred Provider Organizations (PPOs).]

PRVHMO	YES	1
PLHMOERR	NO	2
	REFUSED	-7
	DON'T KNOW	-8

HIS26. Who was listed as the main insured person on the (HIS20 PLAN NAME) policy or contract?
[ENTER ONLY ONE PERSON.]
PLMIPNUM
MIPNUM

HIS27. For the (HIS20 PLAN NAME) plan, did (you/MIP) sign up directly with the (insurance company/managed care plan), or did (you/MIP) get this insurance through a current employer, a former employer, a union, a family business, AARP, or some other way?

PRVGET	DIRECTLY	1	(HIS27a)
PPRVGET	(MIP's) CURRENT EMPLOYER	2	(HIS28)
	(MIP'S) FORMER EMPLOYER	3	(HIS28)
	(MIP'S) UNION	4	(HIS29)
	(MIP'S) FAMILY BUSINESS	5	(HIS27a)
	AARP	6	(HIS27a)
	DECEASED SPOUSE'S EMPLOYER	7	(HIS28)
	DECEASED SPOUSE'S UNION	8	(HIS29)
	PROFESSIONAL/FRATERNAL ORGANIZATION	9	(HIS29)
	SOME OTHER WAY (SPECIFY) _____	91	(HIS29)
PRVGETOS	REFUSED	-7	(HIS29)
PPRVGTOS	DON'T KNOW	-8	(HIS29)

HIS27a. Many Medicare Supplemental or Medigap plans are referred to by a plan letter. There are ten standardized policies, labeled **Plan "A" through Plan "J"**. Did (your/MIP's) (HIS20 PLAN NAME) have a plan letter?

PRVLETR	YES	1	(HIS27b)
	NO	2	***BOX HIS3AA***
	REFUSED	-7	***BOX HIS3AA***
	DON'T KNOW	-8	***BOX HIS3AA***

HIS27b. What was the plan letter for (your/MIP's) (HIS20 PLAN NAME)?

PLANLETR PLAN LETTER _____

BOX HIS3AA	IF HIS27 = 5, GO TO HIS28. OTHERWISE, GO TO HIS29.

HIS28. What kind of business or industry is (RESPONSE IN HIS27)? That is, what does (RESPONSE IN HIS27) make or do?
[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

PRVBUS1	_____	**PPRVBUS1**
PRVBUS2		**PPRVBUS2**
PRVBUS3	_____	**PPRVBUS3**
INDCODE		**PINDCODE**

HIS29. How many family members, including (yourself/SP), were covered by (your/MIP's) (HIS20 PLAN NAME) between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE)?

PRVNMCOV NUMBER COVERED: _____

HIS30. Did (your/MIP's) (HIS20 PLAN NAME) plan cover medicines prescribed by a doctor?

PRVRXCOV

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HIS3A	IF PLAN IS A MANAGED CARE PLAN (HIS25 = 1), GO TO HIS30a. OTHERWISE, GO TO HIS31.

HIS30a. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did (you/SP) have dental coverage through (HIS20 PLAN NAME)?

MHMODENT

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIS30b. Did (you/SP) have optical coverage through (HIS20 PLAN NAME), that is, for eyeglasses or contact lenses?

MHMOEYE

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIS30c. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did (you/SP) have coverage for preventive care such as routine annual physicals through (HIS20 PLAN NAME)?

MHMOPCAR	YES	1	
	NO	2	
	REFUSED	-7	
	DON'T KNOW	-8	

HIS31. Would (your/MIP's) (HIS20 PLAN NAME) plan have covered any part of a stay in a nursing home?

PRVNHCOV	YES	1	
	NO	2	
	REFUSED	-7	
	DON'T KNOW	-8	

HIS32. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did (you/MIP) pay any or all of the premium or cost for the (HIS20 PLAN NAME) coverage?
[Do not include the cost of any deductibles (you/SP) or (your/SP's) family may have had to pay.]

MIPPINS	YES	1	(HIS33)
	NO	2	(HIS33a)
	REFUSED	-7	(HIS33a)
	DON'T KNOW	-8	(HIS33a)

HIS33. How much did (you/MIP) pay for the (HIS20 PLAN NAME) coverage?
[PROBE IF NECESSARY: Was that per year, per month, per week, or what?]

	AMOUNT: $_____._____		
MIPPAMT	PER YEAR	1	
MIPPUNIT	QUARTERLY/EVERY 3 MONTHS	2	
	BIMONTHLY/EVERY 2 MONTHS	3	
	PER MONTH	4	
	PER WEEK	5	
	SEMI-ANNUALLY/2 TIMES PER YEAR	6	
	SEMI-MONTHLY/2 TIMES PER MONTH	7	
MIPPUNOS	OTHER (SPECIFY) _____	91	
	REFUSED	-7	
	DON'T KNOW	-8	

HIS33a. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), did anyone else, such as an employer, a union or professional organization pay all or some portion of the premium or cost for (your/MIP's) (HIS20 PLAN NAME) coverage?

MHMOCOST	YES	1	(HIS33b)
	NO	2	***BOX HIS3B***
	REFUSED	-7	***BOX HIS3B***
	DON'T KNOW	-8	***BOX HIS3B***

HIS33b. Who else paid all or some portion of the cost for (your/MIP's) (HIS20 PLAN NAME) coverage?

MHMOWHO	(MIP's) CURRENT EMPLOYER	1
	(MIP's) FORMER EMPLOYER	2
	(MIP's) UNION	3
	SPOUSE'S CURRENT EMPLOYER	4
	SPOUSE'S FORMER EMPLOYER	5
	PROFESSIONAL/FRATERNAL ORGANIZATION	6
	MEDICAID/MEDICAL ASSISTANCE	7
MHMOWHOS	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

BOX HIS3B	IF PLAN IS A MANAGED CARE PLAN, GO TO HIS33c. OTHERWISE, GO TO ***BOX HIS4***.

HIS33c. Some managed care plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. Between (PREVIOUS ROUND REF. DATE) and (PREVIOUS ROUND INTERVIEW DATE), [were you/was (SP)] enrolled in a point-of-service option offered by (HIS20 PLAN NAME)?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a $10 copayment. However, the member may have to pay 20 percent of the cost and the managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

MHMOPOS	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

BOX HIS4	CYCLE THROUGH QUESTIONS HIS21 - HIS33c FOR EACH PRIVATE PLAN REPORTED AT HIS20. WHEN ALL PLANS ADDED HAVE BEEN DISCUSSED RETURN TO HIS1, LISTING EACH PLAN NAME REPORTED IN HIS20.

HISCLOSE. That covers the health insurance (you/SP) had at the time of the last interview. The next questions are about (your/SP's) insurance coverage between (PREVIOUS ROUND INTERVIEW DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION).

[PRESS ENTER TO CONTINUE.]

BOX HIS4A	ORD AND DUAL ELIGIBLE SAMPLES AND SUPPLEMENTAL SAMPLE CASES: IF ANY CMS MEDICARE MANAGED CARE PLANS WERE LOADED AT HOME OFFICE, GO TO MC1. IF NO CMS MEDICARE MANAGED CARE PLANS WERE LOADED AT HOME OFFICE, GO TO HIMC1. NON-SUPPLEMENTAL SAMPLE CASES, GO TO ***BOX HIS4B***.

BOX HIS4B	IF MEDICARE MANAGED CARE PLAN CURRENT AS OF PREVIOUS INTERVIEW, GO TO HIMC1a. OTHERWISE, GO TO HIMC1.

MEDICARE MANAGED CARE PLAN = XXXXXXX

HIMC1a. At the time of the last interview (you were/SP was) covered by (MEDICARE MANAGED CARE PLAN NAME). [(Are you/Is SP) now covered by (MEDICARE MANAGED CARE PLAN NAME)?] [Was (SP) covered by (MEDICARE MANAGED CARE PLAN NAME) on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]

MHMOSAME	YES	1	***BOX HIS4C***
	NO	2	(HIMC1b)
	REFUSED	-7	***BOX HIMC4***
	DON'T KNOW	-8	***BOX HIMC4***

HIMC1b. [STOPHMO] What is the most important reason (you/SP) stopped the (MEDICARE MANAGED CARE PLAN NAME) coverage?

DISENROL	TOO EXPENSIVE	1	(HIMC1c)
DISENROS	SP DISSATISFIED WITH QUALITY OF CARE	2	(HIMC1c)
	DOCTOR LEFT PLAN/DIED/RETIRED	3	(HIMC1c)
	INCONVENIENT LOCATION	4	(HIMC1c)
	PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE	5	(HIMC1c)
	DIFFICULTIES GETTING APPOINTMENTS	6	(HIMC1c)
	DIFFICULTY SEEING PROVIDERS SP WANTED TO SEE	7	(HIMC1c)
	COULDN'T GET NEEDED CARE	8	(HIMC1c)
	DOCTOR DID NOT SPEAK SP'S LANGUAGE	9	(HIMC1c)
	SP MOVED	10	(HIMC1c)
	SP WANTED OR NEEDED DIFFERENT HEALTH CARE BENEFITS	11	(HIMC1c)
	SP COULD NOT AFFORD THE PLAN'S PREMIUMS, DEDUCTIBLES, AND/OR COPAYMENTS	12	(HIMC1c)
	SP DIDN'T LIKE CHOICE OF DOCTORS	13	(HIMC1c)
	SP WANTED CHOICE OF DOCTORS	14	(HIMC1c)
	REACHED BENEFIT LIMIT	15	(HIMC1c)
	PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER MANAGED CARE PLAN	16	(HIMC3)
	OTHER (SPECIFY) _____	91	(HIMC1c)
	REFUSED	-7	(HIMC1c)
	DON'T KNOW	-8	(HIMC1c)

BOX HIS4C	IF THIS PLAN NOT "CURRENT" IN PREVIOUS ROUND OR IF THIS PLAN "CURRENT" AND THIS ROUND SUPPLEMENTAL SAMPLE ADDED, GO TO HIMC6. OTHERWISE, GO TO ***BOX HIMC2***.

HIMC1c. [Since (REF. DATE)/Between (REF. DATE) and (DATE OF DEATH/INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Managed Care Plans besides (MEDICARE MANAGED CARE PLAN CURRENT LAST ROUND)?

SHOW CARD HIMC1

MHMOOTHR

YES	1	(HIMC3)
NO	2	***BOX HIMC4***
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	***BOX HIMC4***

BOX MC1 OMITTED.

MC1. [The next questions are about health insurance.] As you may know, Medicare allows beneficiaries in certain parts of the country to enroll in managed care plans, such as HMOs (health maintenance organizations), to receive their Medicare-funded health care. According to Medicare records, (you are/SP is) currently enrolled in a Medicare Managed Care Plan called (CMS MEDICARE MANAGED CARE PLAN NAME). Is this information correct?

LOADCORR

YES	1	(HIMC6)
NO	2	(MC2)
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	(MC11)

MC2. (CMS MEDICARE MANAGED CARE PLAN NAME)

How is this information incorrect?
[CODE ONLY ONE. IF MORE THAN ONE CODE APPLICABLE, ENTER THE LOWEST NUMBER CODE.]

WHATWRNG

SP NOW DISENROLLED FROM (CMS MEDICARE MANAGED CARE PLAN NAME), ENROLLED IN NEW MEDICARE MANAGED CARE PLAN	1	(MC2a)
SP HAS PLAN CALLED (CMS MEDICARE MANAGED CARE PLAN NAME), R DOESN'T THINK IT'S A MEDICARE MANAGED CARE PLAN	2	(MC3)
SP NOW DISENROLLED FROM (CMS MEDICARE MANAGED CARE PLAN NAME), NO LONGER IN ANY MEDICARE MANAGED CARE PLAN	3	(MC2a)
SP ENROLLED IN MEDICARE MANAGED CARE PLAN, BUT NEVER (CMS MEDICARE MANAGED CARE PLAN NAME)	4	(MC4)
SP NEVER COVERED BY OR ENROLLED IN (CMS MEDICARE MANAGED CARE PLAN NAME)	5	(MC11)

MC2a. What is the most important reason (you/SP) stopped the (CMS MEDICARE MANAGED CARE PLAN NAME) coverage?

DISENROL	TOO EXPENSIVE	1	***BOX MC1A***
DISENROS	SP DISSATISFIED WITH QUALITY OF CARE	2	***BOX MC1A***
	DOCTOR LEFT PLAN/DIED/RETIRED	3	***BOX MC1A***
	INCONVENIENT LOCATION	4	***BOX MC1A***
	PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE	5	***BOX MC1A***
	DIFFICULTIES GETTING APPOINTMENTS	6	***BOX MC1A***
	DIFFICULTY SEEING PROVIDERS SP WANTED TO SEE	7	***BOX MC1A***
	COULDN'T GET NEEDED CARE	8	***BOX MC1A***
	DOCTOR DID NOT SPEAK SP'S LANGUAGE	9	***BOX MC1A***
	SP MOVED	10	***BOX MC1A***
	SP WANTED OR NEEDED DIFFERENT HEALTH CARE BENEFITS	11	***BOX MC1A***
	SP COULD NOT AFFORD THE PLAN'S PREMIUMS, DEDUCTIBLES, AND/OR COPAYMENTS	12	***BOX MC1A***
	SP DIDN'T LIKE CHOICE OF DOCTORS	13	***BOX MC1A***
	SP WANTED CHOICE OF DOCTORS	14	***BOX MC1A***
	REACHED BENEFIT LIMIT	15	***BOX MC1A***
	PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER MANAGED CARE PLAN	16	***BOX MC1A***
	OTHER (SPECIFY) _____	91	***BOX MC1A***
	REFUSED	-7	***BOX MC1A***
	DON'T KNOW	-8	***BOX MC1A***

BOX MC1A	IF MC2=1, GO TO MC5. IF MC2 = 3, GO TO HIMC16.

MC3. In many Medicare Managed Care Plans, such as health maintenance organizations, the health plan gives the patient a list of doctors from which he chooses a primary care physician. This primary care physician provides the patient's usual medical care and can refer the patient to specialists, if necessary. (Do you/Does SP) have a primary care physician?

PRIMPHYS	YES	1	(HIMC6)
	NO	2	(HIMC6)
	REFUSED	-7	(HIMC6)
	DON'T KNOW	-8	(HIMC6)

MC4. Is it possible that (your/SP's) current insurance plan is just another name for (CMS MEDICARE MANAGED CARE PLAN NAME), or are they not the same plans?

SAMEPLAN	SAME PLANS	1	***BOX MC2***
	NOT THE SAME PLANS	2	(MC5)
	REFUSED	-7	(MC5)
	DON'T KNOW	-8	(MC5)

MC5. What is the name of the Medicare Managed Care Plan that provides (your/SP's) health care?
GO TO ***BOX MC2***.

[ENTER ONLY ONE PLAN.]
PLNAME

MC6-MC7 OMITTED.

BOX MC3 OMITTED.

MC8-MC9 OMITTED.

BOX MC4 OMITTED.

MC10 OMITTED.

MC11. Do you refer to (your/SP's) Medicare coverage by any name besides Medicare?

REFERMED

MEDICARE ONLY	1	***BOX HIMC4***
OTHER NAME	2	(MC12)
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	***BOX HIMC4***

MC12. What do you call (your/SP's) coverage?
[ENTER ONLY ONE PLAN.]
PLNAME

BOX MC2	FLAG THE CMS MEDICARE MANAGED CARE PLAN AS CURRENT MEDICARE MANAGED CARE PLAN OR THE PLAN ADDED AT MC5/MC12 AS CURRENT MEDICARE MANAGED CARE PLAN. THEN GO TO HIMC6.

MC13 OMITTED.

HIMC1. [The next questions are about health insurance.] As you (may) know, Medicare allows beneficiaries in certain parts of the country to enroll in managed care plans, such as HMOs (health maintenance organizations), to receive their Medicare-funded health care.
(Please look at this card.) At any time since (REF. DATE), (have you/has SP/had SP) been enrolled in or covered by (one of these/any) Medicare Managed Care Plans?

SHOW CARD HIMC1

MHMOCOV

YES	1	(HIMC3)
NO	2	***BOX HIMC1A***
REFUSED	-7	***BOX HIMC1A***
DON'T KNOW	-8	***BOX HIMC1A***

BOX HIMC1A	SKIP PATTERN FOR FALL "SUPPLEMENTAL" SAMPLE ROUNDS: IF SP NEVER ENROLLED IN MEDICARE MANAGED CARE PLAN (NO PLANTYPE = 5 ON PLAN ROSTER) AND SP NOT DECEASED, THEN GO TO HIMC1INT. OTHERWISE, GO TO ***BOX HIMC4***. SKIP PATTERN FOR ALL OTHER ROUNDS: GO TO ***BOX HI1***.

HIMC1INT. [In some areas, Medicare beneficiaries like (yourself/SP) can join managed care plans, such as health maintenance organizations (HMOs).] The managed care plan provides all (your/SP's) care for a fixed fee, rather than billing Medicare for each service. In many Medicare Managed Care Plans, the primary care doctor authorizes, arranges, and coordinates all services for (you/SP).
[PRESS ENTER TO CONTINUE.]

HIMC1aa. Before today, had you ever heard of managed care plans that Medicare beneficiaries can join?

HEARMHMO

YES	1	(HIMC1bb)
NO	2	***BOX HI1***
REFUSED	-7	***BOX HI1***
DON'T KNOW	-8	***BOX HI1***

HIMC1bb. Are there managed care plans in (your/SP's) area that Medicare beneficiaries can join?

AREAMHMO

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIMC1cc. OMITTED IN ROUND 20.

HIMC1cc1. Would (you/SP) prefer to have (more) managed care plans offered in (your/his/her) area?

OFFRAREA

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HIMC1AA	IF HIMC1bb = 2 OR DK, GO TO HIMC1dd. OTHERWISE, GO TO HIMC1cc2.

HIMC1cc2. Would (you/SP) prefer to have managed care plans in (your/his/her) area that offer different services or features than those currently available?

DIFFSRVC

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIMC1dd. How satisfied are you with the information available to (you/SP) to make health coverage choices?

SHOW CARD HIMC2

HIINFO

VERY SATISFIED	1
SATISFIED	2
DISSATISFIED	3
VERY DISSATISFIED	4
REFUSED	-7
DON'T KNOW	-8

HIMC1ee. What additional kinds of information would you like to have to be able to make health coverage choices (for SP)?

HIADDINF	NO ADDITIONAL INFORMATION NEEDED/WANTED	1	**VCHIADD1**
HIADDVB1	RECORD ALL OTHER RESPONSES VERBATIM BELOW	91	**VCHIADD2**
HIADDVB2	_____		**VCHIADD3**
HIADDVB3	_____		**VCHIADD4**

BOX HIMC1B

IF FIRST-TIME COMMUNITY CASE AND:
IF HIMC1bb = 1, REF, DK, GO TO HIMC1ff.
IF HIMC1bb = 2, GO TO HIMC1hh.
OTHERWISE, GO TO ***BOX HI1***.

HIMC1ff. (Have you/Has SP) considered joining a managed care plan since becoming a Medicare beneficiary?

JOINMHMO

YES	1	***BOX HI1***
NO	2	(HIMC1gg)
REFUSED	-7	***BOX HI1***
DON'T KNOW	-8	***BOX HI1***

HIMC1gg. Why (haven't you/hasn't SP) considered joining a managed care plan?
[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

JOINHMO1	_____	**VCJOIN1**
JOINHMO2	_____	**VCJOIN2**
JOINHMO3	_____	**VCJOIN3**
	_____	**VCJOIN4**

GO TO ***BOX HI1***

HIMC1hh. If there were managed care plans in (your/SP's) area that Medicare beneficiaries could join, would [you/(SP)] consider joining?

IFMHMO

YES	1	***BOX HI1***
NO	2	(HIMC1ii)
REFUSED	-7	***BOX HI1***
DON'T KNOW	-8	***BOX HI1***

HIMC1ii. Why wouldn't (you/SP) consider joining a managed care plan?
[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

IFMHMO1	_____	**VCIFMH1**
IFMHMO2	_____	**VCIFMH2**
IFMHMO3	_____	**VCIFMH3**
	_____	**VCIFMH4**

GO TO ***BOX HI1***

HIMC2 OMITTED.

BOX HIMC1BB OMITTED.

HIMC3. (Are you/Is SP/Was SP) (currently) covered by or enrolled in a Medicare Managed Care Plan (on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

MHMOCURR

YES	1	(HIMC5)
NO	2	***BOX HIMC1C***
REFUSED	-7	***BOX HIMC1C***
DON'T KNOW	-8	***BOX HIMC1C***

BOX HIMC1C	IF COMING FROM CHARGE SERIES OR INTERRUPT, RETURN TO CHARGE SERIES OR INTERRUPT. OTHERWISE, GO TO HIMC17.

HIMC4. I recorded previously that (CURRENT MEDICARE MANAGED CARE PLAN NAME) was (your/SP's) current Medicare Managed Care Plan. Has this information changed?

MHMOCHNG

YES	1	(HIMC5)
NO	2	(ST/NS/CT/CPS)
REFUSED	-7	(ST/NS/CT/CPS)
DON'T KNOW	-8	(ST/NS/CT/CPS)

HIMC5. [What is the name of the Medicare Managed Care Plan that (currently covers/covered) (you/SP) (on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]
[ENTER ONLY ONE PLAN.]
PLNAME

BOX HIMC1	IF THIS IS THE FALL "SUPPLEMENTAL" ROUND OR HIMC6 NEVER ASKED FOR THIS MEDICARE MANAGED CARE PLAN OR IF THIS MEDICARE MANAGED CARE PLAN WAS SELECTED (I.E., THE SP HAS RE-STARTED THIS PLAN), GO TO HIMC6. OTHERWISE, GO TO ***BOX HI1***/ST/NS/CT/CPS.

HIMC6. (Do you/Does SP/Did SP) have prescribed medicine coverage through (CURRENT MEDICARE MANAGED CARE PLAN NAME)?

[PROBE: I am asking about the type of insurance coverage that (you personally have/SP personally has), not what the plan offers everyone.]

MHMORX

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIMC7. (Do you/Does SP/Did SP) have dental coverage through (CURRENT MEDICARE MANAGED CARE PLAN NAME)?

MHMODENT

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIMC8. (Do you/Does SP/Did SP) have optical coverage through (CURRENT MEDICARE MANAGED CARE PLAN NAME), that is, for eyeglasses or contact lenses?

MHMOEYE

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIMC9. (Do you/Does SP/Did SP) have coverage for preventive care such as routine annual physicals through (CURRENT MEDICARE MANAGED CARE PLAN NAME)?

MHMOPCAR

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIMC10. (Does your/Does SP's/Did SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage include nursing home care over and beyond what Medicare normally covers?

[EXPLAIN IF NECESSARY: Under regular fee-for-service, Medicare pays for limited skilled nursing facility (SNF) care during a benefit period. In 2002, the first 20 days are paid in full and the next 80 days require a copayment of up to $101.50 per day.]

MHMONH

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HIMC11. Besides the cost of (your/SP's) Medicare Part B premium, is there an additional cost for (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage? Please do not include any amount that (you/SP) may pay as a co-payment for an office visit or a prescribed medicine.

[EXPLAIN IF NECESSARY: Some managed care plans may charge a monthly premium to cover the cost of the deductibles and coinsurance for normal Medicare services or because they provide services that are not covered by Medicare such as prescribed medicines, routine exams, and dental, eye, or hearing. Plans that have premiums typically charge from $50 to $75 per month.]

MHMOPAY	YES	1	(HIMC12)
	NO	2	***BOX HIMC1D***
	REFUSED	-7	***BOX HIMC1D***
	DON'T KNOW	-8	***BOX HIMC1D***

HIMC12. Not including the cost of (your/SP's) Medicare Part B premium, what is the <u>additional</u> amount that [you pay/(SP) pays] for (your/his/her) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage? [Please do not include any copayments (or any amount that may be paid for (your/SP's) spouse's coverage).]

AMOUNT $ _____._____ PER ( )

[PROBE IF NECESSARY: Is that per year, per month, per week, or what?]

MHMOAMT	PER YEAR	1
MHMOUNIT	QUARTERLY/EVERY 3 MONTHS	2
MHMOUNOS	BIMONTHLY/EVERY 2 MONTHS	3
	PER MONTH	4
	PER WEEK	5
	SEMI-ANNUALLY/2 TIMES PER YEAR	6
	SEMI-MONTHLY/2 TIMES PER MONTH	7
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HIMC12a. Does anyone else, such as an employer, a union or professional organization pay all or some portion of the additional cost for (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage?

MHMOCOST	YES	1	(HIMC12b)
	NO	2	***BOX HIMC1D***
	REFUSED	-7	***BOX HIMC1D***
	DON'T KNOW	-8	***BOX HIMC1D***

HIMC12b. Who else pays all or some portion of the additional cost for (your/SP's) (CURRENT MEDICARE MANAGED CARE PLAN NAME) coverage?

	(SP'S) CURRENT EMPLOYER	1
	(SP'S) FORMER EMPLOYER	2
	(SP'S) UNION	3
MHMOWHO	SPOUSE'S CURRENT EMPLOYER	4
	SPOUSE'S FORMER EMPLOYER	5
	PROFESSIONAL/FRATERNAL ORGANIZATION	6
MHMOWHOS	MEDICAID/MEDICAL ASSISTANCE	7
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HIMC13. OMITTED IN ROUND 18.

BOX HIMC1D	IF HIMC14 NEVER ASKED FOR THIS MEDICARE MANAGED CARE PLAN OR IF THIS MEDICARE MANAGED CARE PLAN WAS SELECTED (I.E., THE SP HAS RE-STARTED THIS PLAN), GO TO HIMC14. OTHERWISE, GO TO HIMC15.

HIMC14. What is the most important reason (you/SP) decided to become a member of (CURRENT MEDICARE MANAGED CARE PLAN NAME)?

SHOW CARD HIMC2A

MHMOMEMB **MHMOMEOS**	LOWER COST	1
	BETTER BENEFITS OR COVERAGE	2
	DOCTOR WAS MEMBER	3
	CONVENIENT LOCATION	4
	RECOMMENDATION OR REPUTATION	5
	SP'S CURRENT/FORMER EMPLOYER PAYS PREMIUM	6
	SPOUSE'S CURRENT/FORMER EMPLOYER PAYS PREMIUM	7
	LESS PAPERWORK	8
	PREVIOUS MANAGED CARE PLAN NAME CHANGED OR WAS BOUGHT BY/ MERGED WITH CURRENT PLAN	9
	BETTER SELECTION OF PROVIDERS	10
	BETTER QUALITY OF CARE	11
	COULDN'T GET MEDICARE SUPPLEMENTAL INSURANCE (MEDIGAP)	12
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

HIMC15. Some Medicare Managed Care Plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. [Are you/Is (SP)/Was (SP)] enrolled in a point-of-service option offered by (CURRENT MEDICARE MANAGED CARE PLAN)?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a $10 copayment. However, the member may have to pay 20 percent of the cost and the managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

MHMOPOS

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HIMC2	IF COMING FROM CHARGE SERIES OR INTERRUPT, RETURN TO CHARGE SERIES OR INTERRUPT. IF CURRENT MEDICARE MANAGED CARE PLAN IS SAME PLAN AS PREVIOUS ROUND MEDICARE MANAGED CARE PLAN (HIMC1a=1), GO TO ***BOX HIMC4***. OTHERWISE, GO TO HIMC16.

HIMC16. [Since (REFERENCE DATE)/Between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/ INSTITUTIONALIZATION)], [have you/has (SP)/had (SP)] been covered by any other Medicare Managed Care Plans besides (CURRENT MEDICARE MANAGED CARE PLAN) [and (MEDICARE MANAGED CARE PLAN)]?

SHOW CARD HIMC1

MHMOMORE

YES	1	(HIMC17)
NO	2	***BOX HIMC4***
REFUSED	-7	***BOX HIMC4***
DON'T KNOW	-8	***BOX HIMC4***

HIMC17. [Besides (CURRENT MEDICARE MANAGED CARE PLAN) [and (MEDICARE MANAGED CARE PLAN)]], what (other) Medicare Managed Care Plans provided (your/SP's) health care since (REFERENCE DATE)?

[ENTER ALL PLAN NAMES.]
PLNAME

BOX HIMC3	FOR EACH PLAN ADDED OR SELECTED AT HIMC17, GO TO HIMC18.

HIMC18. What is the most important reason (you/SP) stopped the (MEDICARE MANAGED CARE PLAN NAME) [STOPHMO] coverage?

DISENROL	TOO EXPENSIVE	1
DISENROS	SP DISSATISFIED WITH QUALITY OF CARE	2
	DOCTOR LEFT PLAN/DIED/RETIRED	3
	INCONVENIENT LOCATION	4
	PLAN WENT OUT OF BUSINESS/STOPPED MEDICARE COVERAGE	5
	DIFFICULTIES GETTING APPOINTMENTS	6
	DIFFICULTY SEEING PROVIDERS SP WANTED TO SEE	7
	COULDN'T GET NEEDED CARE	8
	DOCTOR DID NOT SPEAK SP'S LANGUAGE	9
	SP MOVED	10
	SP WANTED OR NEEDED DIFFERENT HEALTH CARE BENEFITS	11
	SP COULD NOT AFFORD THE PLAN'S PREMIUMS, DEDUCTIBLES, AND/OR COPAYMENTS	12
	SP DIDN'T LIKE CHOICE OF DOCTORS	13
	SP WANTED CHOICE OF DOCTORS	14
	REACHED BENEFIT LIMIT	15
	PLAN NAME CHANGED OR PLAN WAS BOUGHT BY/MERGED WITH ANOTHER MANAGED CARE PLAN	16
	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

BOX HIMC4	SKIP PATTERN FOR FALL "SUPPLEMENTAL" SAMPLE ROUND: IF SP IS DECEASED, GO TO ***BOX HI1***. NON-DECEASED SPS: GO TO HIMC20a IF SP NOT CURRENTLY IN A MEDICARE MANAGED CARE PLAN. OTHERWISE, GO TO HIMC19. SKIP PATTERN FOR ALL OTHER ROUNDS: GO TO ***BOX HI1***.

HIMC19. Would you recommend (CURRENT MEDICARE MANAGED CARE PLAN NAME) to your family or friends?

RECMHMO	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

HIMC20. OMITTED IN ROUND 20.

HIMC20a. Would (you/SP) prefer to have more managed care plans offered in (your/his/her) area?

OFFRAREA	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

HIMC20b. Would (you/SP) prefer to have managed care plans in (your/his/her) area that offer different services or features than those currently available?

DIFFSRVC	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

HIMC21. How satisfied are you with the information available to (you/SP) to make health coverage choices?

SHOW CARD HIMC2	**HIINFO**	VERY SATISFIED	1
		SATISFIED	2
		DISSATISFIED	3
		VERY DISSATISFIED	4
		REFUSED	-7
		DON'T KNOW	-8

HIMC22. What additional kinds of information would you like to have to be able to make health coverage choices (for SP)?

HIADDINF	NO ADDITIONAL INFORMATION NEEDED/WANTED	1	**VCHIADD1**
	RECORD ALL OTHER RESPONSES VERBATIM BELOW	91	**VCHIADD2**
HIADDVB1	_____		**VCHIADD3**
HIADDVB2	_____		**VCHIADD4**
HIADDVB3	_____		

BOX HIMC5	GO TO ***BOX HI1*** IF SP NOT CURRENTLY IN A MEDICARE MANAGED CARE PLAN OR IF HIMC24 HAS BEEN ASKED AT ANY TIME. OTHERWISE, GO TO HIMC24.

HIMC23. OMITTED IN ROUND 28.

HIMC24. How many years (have you/has SP) been enrolled in a managed care plan?

[ENTER 96 IF LESS THAN 1 YEAR.]

HMONUMYR	NUMBER OF YEARS _____	
	REFUSED	-7
	DON'T KNOW	-8

BOX HI1	IF PLAN ADDED IN ST/NS/CT/CPS, RETURN TO ST/NS/CT/CPS. OTHERWISE: IF SP COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI6 FOR THIS ROUND. IF SP NOT COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI5INTRO.

HIINTRO OMITTED IN ROUND 31.

HI1-HI4h OMITTED IN ROUND 31.
BOX HI1AA OMITTED IN ROUND 31.

BOX HI1A OMITTED IN ROUND 31.

HI5INTRO. [MEDICAID PROGRAM NAME]
[PLEASE READ THIS INTRODUCTION SLOWLY AND CLEARLY:]

MEDICAID (,also known as [READ FROM ABOVE],) is a state program for low income persons or for persons on public assistance. Sometimes persons with very large medical bills are also covered by MEDICAID. People covered by MEDICAID usually have a card that looks like this.

SHOW CARD HI3

[PRESS ENTER TO CONTINUE.]

BOX HI1B	IF STATE IN WHICH INTERVIEW IS BEING CONDUCTED DOES NOT OFFER A MEDICAID MANAGED CARE PLAN, GO TO HI5. OTHERWISE, GO TO HI5INTRB.

HI5INTRB. Some people receive their Medicaid benefits from plans that have names like those listed on this card.

SHOW CARD HI4

[PRESS ENTER TO CONTINUE.]

HI5. At any time [since (REF. DATE), (have you/has SP) been/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION) was (SP)] covered by MEDICAID?

AIDCOVER

YES	1	(HI6)
NO	2	***BOX HI2***
REFUSED	-7	***BOX HI2***
DON'T KNOW	-8	***BOX HI2***

BOX HI2	IF 2, REF OR DK AND SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND. IF 2, REF OR DK AND SP NOT COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI11 FOR THIS ROUND.

HI6. [MEDICAID PROGRAM NAME]
(At the time of the last interview (you were/SP was) covered by MEDICAID(, also known as [READ FROM ABOVE].) (Were you/Was SP) covered by MEDICAID the whole time between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION), or only part of the time?

COVTIME	THE WHOLE TIME	1	***BOX HI5A***
	PART OF THE TIME	2	(HI7)
	REFUSED	-7	(HI10a)
	DON'T KNOW	-8	(HI7)

BOX HI3 OMITTED IN ROUND 25.

HI7. [(Are you/Is SP) now covered by MEDICAID?]/
[Was (SP) covered by MEDICAID on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]

COVNOW	YES	1	***BOX HI4***
	NO	2	(HI9)
	REFUSED	-7	(HI10a)
	DON'T KNOW	-8	(HI10a)

BOX HI4	IF SP COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO ***BOX HI5A***. IF SP NOT COVERED BY MEDICAID IN PREVIOUS ROUND, GO TO HI8.

HI8. On what date did (your/SP's) MEDICAID start between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

COVBEGMM **COVBEGDD** **COVBEGYY** _____/_____/_____
MM DD YY

BOX HI5A	IF SP <u>NOT</u> DECEASED OR INSTITUTIONALIZED, GO TO HI10. OTHERWISE, GO TO HI10a.

BOX HI5 OMITTED IN R20.

HI9. On what date [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)], did (your/SP's) Medicaid coverage (most recently/last) stop?

COVENDMM **COVENDDD** **COVENDYY** _____/_____/_____ (HI10a)
MM DD YY

BOX HI6 OMITTED IN R20.

HI10. May I please see (your/SP's) MEDICAID card to verify the date and type of coverage? [IF DATE NOT SHOWN, CODE AS "CURRENT".]

AIDTYPE	CARD AVAILABLE, CURRENT	1	
	CARD AVAILABLE, EXPIRED	2	
	CARD NOT AVAILABLE OR NOT SEEN	3	(HI10a)
AIDTYPOS	OTHER CARD SEEN (SPECIFY) _____	91	

(DOES THE CARD INDICATE SP'S PARTICIPATION IN MEDICAID PROGRAMS SUCH AS QMB, SLMB, OR QI?)

AIDCARD	YES	1	(HI10aa)
	NO	2	(HI10a)
	CAN'T TELL	3	(HI10a)

HI10aa. SELECT MEDICAID PROGRAMS AS LISTED ON SP'S MEDICAID CARD. (DO NOT INCLUDE THE STATE NAME: [MEDICAID PROGRAM NAME].)

[SELECT ALL THAT APPLY. PRESS CTRL/L TO LEAVE THE SCREEN. DO NOT PROBE FOR ADDITIONAL MEDICAID PROGRAMS.]

AIDQMB	QMB (QUALIFIED MEDICARE BENEFICIARY PROGRAM)	1
AIDSLMB	SLMB (SPECIFIED LOW-INCOME MEDICARE BENEFICIARY PROGRAM)	2
AIDQI	QI (QUALIFYING INDIVIDUAL PROGRAM)	3
AIDOTHR	OTHER PROGRAM (SPECIFY) _____	91
AIDOTHOS		

HI10a. [Some states now use managed care plans, such as HMOs (health maintenance organizations), to provide some or all health care for Medicaid beneficiaries.] [At the time of the last interview (you were/SP was) enrolled in a Medicaid Managed Care Plan.] (Are you now/Is SP now/Were you/Was SP) enrolled in a Medicaid Managed Care Plan [as of (DATE OF DEATH)/(DATE OF INSTITUTIONALIZATION)/(MEDICAID COVERAGE STOP DATE)/the date (your/SP's) Medicaid coverage stopped]?

MCAIDHMO	YES	1	***BOX HI5B***
	NO	2	***BOX HI5C***
	REFUSED	-7	***BOX HI5D***
	DON'T KNOW	-8	***BOX HI5D***

BOX HI5B	IF MCAIDHMO ≠ 1 IN THE PREVIOUS ROUND OR THIS MEDICAID PLAN WAS NOT "CURRENT" AT THE TIME OF THE LAST INTERVIEW, GO TO HI10b. OTHERWISE, GO TO ***BOX HI5D***.

BOX HI5C	IF MCAIDHMO = 1 IN PREVIOUS ROUND, MEDICAID WAS "CURRENT" AT THE TIME OF THE LAST INTERVIEW AND HI6 = 1 FOR CURRENT ROUND, GO TO HI10c. OTHERWISE, GO TO ***BOX HI5D***.

HI10b. As far as you can recall, (were you/was SP) given a choice to enroll in a Medicaid Managed Care Plan, or did (you/he/she) have to enroll to receive Medicaid benefits?

CHOICHMO

GIVEN A CHOICE TO ENROLL	1	***BOX HI5D***
HAD TO ENROLL	2	***BOX HI5D***
DOESN'T REMEMBER	3	***BOX HI5D***
REFUSED	-7	***BOX HI5D***
DON'T KNOW	-8	***BOX HI5D***

HI10c. Why (do you/does SP) no longer receive (your/his/her) Medicaid benefits through a managed care plan?

[RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

_____ **MCAIDVB1**

_____ **MCAIDVB2**

_____ **MCAIDVB3**

BOX HI5D	(A) IF MEDICAID WAS NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI10d. (B) IF MEDICAID WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HI10d. (C) OTHERWISE, GO TO ***BOX HI7***.

HI10d. (Does/Did) [your/(SP's)] Medicaid plan cover medicines prescribed by a doctor?

MCDRXCOV

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HI7	IF SP COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI13 FOR THIS ROUND. IF SP NOT COVERED BY PUBLIC PLAN IN PREVIOUS ROUND, GO TO HI11 FOR THIS ROUND.

HI11. At any time [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)], [(have you/has SP) been/was (SP)] covered by any <u>other</u> public program that pays for medical care, [for example, a public program that pays for prescribed medicines/for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM), a public program that pays for prescribed medicines/ for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM1) or (STATE PHARMACEUTICAL ASSISTANCE PROGRAM2)/for example (STATE PHARMACEUTICAL ASSISTANCE PROGRAM1), (STATE PHARMACEUTICAL ASSISTANCE PROGRAM2), or (STATE PHARMACEUTICAL ASSISTANCE PROGRAM3), public programs that pay for prescribed medicines]?

D_PUBLIC

YES	1	(HI12)
NO	2	***BOX HI8***
REFUSED	-7	***BOX HI8***
DON'T KNOW	-8	***BOX HI8***

BOX HI8	IF 2, REF, OR DK AND SP COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND. IF 2, REF OR DK AND SP NOT COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.

HI12. What is the name of the public program that covered (you/SP)?
[ENTER ALL PUBLIC PROGRAMS.]
PLNAME

OTHER PUBLIC PROGRAM = XXXXXXX

HI13. [At the time of the last interview (you were/SP was) covered by (PUBLIC PLAN NAME).] (Were you/Was SP) covered by (PUBLIC PLAN NAME) the whole time between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION), or only part of the time?

COVTIME

THE WHOLE TIME	1	***BOX HI9***
PART OF THE TIME	2	(HI14)
REFUSED	-7	***BOX HI9***
DON'T KNOW	-8	(HI14)

BOX HI9	(A) IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI16a. (B) IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HI16a. (C) OTHERWISE, ASK HI13 FOR NEXT PREVIOUS ROUND PUBLIC PLAN OR GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND. (D) ASK HI13 FOR EACH NEW PUBLIC PLAN COLLECTED IN HI12. (E) IF SP COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND. IF SP NOT COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.

HI14. [(Are you now/Is (SP) now/Was (SP)) covered by (PUBLIC PLAN NAME)?] [Was (SP) covered by (PUBLIC PLAN NAME) on (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?]

COVNOW

YES	1	***BOX HI10***
NO	2	(HI16)
REFUSED	-7	***BOX HI10***
DON'T KNOW	-8	***BOX HI10***

BOX HI10	(A) IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND AND HI14 = 1, GO TO HI15. (B) IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND AND HI14 = REF OR DK, GO TO HI16a. (C) IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HI16a. (D) OTHERWISE, ASK HI13 FOR NEXT PREVIOUS ROUND PUBLIC PLAN OR GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND. (E) ASK HI13 FOR EACH NEW PUBLIC PLAN COLLECTED IN HI12. (F) IF SP COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI21 FOR THIS ROUND. IF SP NOT COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI17 FOR THIS ROUND.

HI15. On what date did (your/SP's) (PUBLIC PLAN NAME) coverage start between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

COVBEGMM
COVBEGDD
COVBEGYY

_____/_____/_____ (HI16a)
MM DD YY

BOX HI11 OMITTED IN ROUND 25.

HI16. On what date [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and [DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)] did (your/SP's) (PUBLIC PLAN NAME) coverage (most recently/last) stop?

COVENDMM
COVENDDD
COVENDYY

_____/_____/_____
MM DD YY

BOX HI11A	(A) IF THIS PLAN WAS NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI16a. IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS A FALL "SUPPLEMENTAL" SAMPLE ROUND, GO TO HI16a. OTHERWISE, (IF THIS PLAN WAS "CURRENT" IN PREVIOUS ROUND AND IT IS NOT A FALL "SUPPLEMENTAL" ROUND), GO TO (B). (B) IF THERE ARE MORE PUBLIC PLANS FROM PREVIOUS ROUND, GO TO HI13 FOR NEXT PUBLIC PLAN FROM PREVIOUS ROUND. IF NO MORE PUBLIC PLANS FROM PREVIOUS ROUND, GO TO HI11 TO COLLECT NEW PUBLIC PLANS FOR THIS ROUND.

HI16a. (Does/Did) [your/(SP's)] (PUBLIC PLAN NAME) plan cover medicines prescribed by a doctor?

PUBRXCOV

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HI12	IF HI16a BEING ASKED FOR PUBLIC PLAN FROM PREVIOUS ROUND, GO TO HI13 FOR NEXT PUBLIC PLAN FROM PREVIOUS ROUND. IF NO MORE PUBLIC PLANS FROM PREVIOUS ROUND, GO TO HI11 TO COLLECT ANY NEW PUBLIC PLANS FOR THIS ROUND. IF HI16a BEING ASKED FOR PUBLIC PLAN COVERAGE FOR THIS ROUND, GO TO HI13 FOR NEXT PUBLIC PLAN ADDED THIS ROUND. IF NO MORE PUBLIC PLAN COVERAGE FOR THIS ROUND, FOLLOW THESE SKIP PATTERNS: (1) IF SP COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI21 FOR FIRST PRIVATE PLAN. (2) IF SP NOT COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, GO TO HI17.

HI17. We've talked about [READ PLAN(S) LISTED BELOW].

[HI17A, HI17B]

(Now, I would like to ask about other types of health insurance.) At any time [since (REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/DATE OF INSTITUTIONALIZATION)], [(have you/has SP) been/was (SP)] covered by (any other) private health insurance or private managed care plan(s)?

[PROBE: A plan that covers the cost of hospital or doctor visits, prescribed medicines, or dental care?]

D_TYPPL1
D_TYPPL2
D_TYPPL3
D_TYPPL4
D_TYPPL5

YES	1	(HI20)
NO	2	***BOX HI13***
REFUSED	-7	***BOX HI13***
DON'T KNOW	-8	***BOX HI13***

BOX HI13	IF 2, REF OR DK AND SP WAS COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, AND SP SERVED IN THE ARMED FORCES (I.E., EN9 OR EN11=1), GO TO ***BOX HI20***. IF 2, REF OR DK AND SP WAS COVERED BY PRIVATE HEALTH INSURANCE IN PREVIOUS ROUND, AND SP DID NOT SERVE IN THE ARMED FORCES (I.E., EN9 AND EN11=2, REF, DK, OR -9), GO TO ***BOX HI21A***. OTHERWISE, GO TO ***BOX HI13A***.

HI18 OMITTED.

BOX HI13A	IF 2, REF, DK AND SUPPLEMENTAL SAMPLE OR 1ST COMMUNITY INTERVIEW (INTERVIEW TYPE = 2), GO TO HI19. OTHERWISE, GO TO HI34.

HI19. Some people who are eligible for Medicare have additional coverage through a private insurance carrier. This is sometimes referred to as Medigap or Medicare Supplement. At any time since (REF. DATE) did (you/SP) have this type of health insurance coverage?

GAPCOVER

YES	1	(HI20)
NO	2	(HI34)
REFUSED	-7	(HI34)
DON'T KNOW	-8	(HI34)

HI20. What is the name of each of the (other) private plans that provide(d) (your/SP's) medical insurance coverage? [ENTER ALL PRIVATE PLANS.]
PLNAME

BOX HI14	ASK HI21 - HI33c FOR EACH PLAN COLLECTED IN HI20.

HI21. PRIVATE INSURANCE PLAN = (PLAN NAME)

[HI21A, HI21] [At the time of the last interview (you were/SP was) covered by (PRIVATE PLAN NAME).] (Were you/Was SP) covered by (PLAN NAME) the whole time between (REF. DATE) and (today/ DATE OF DEATH/DATE OF INSTITUTIONALIZATION), or only part of the time?

COVTIME

THE WHOLE TIME	1	***BOX HI15***
PART OF THE TIME	2	(HI22)
REFUSED	-7	***BOX HI15***
DON'T KNOW	-8	(HI22)

BOX HI14A OMITTED.

BOX HI15	IF THIS PLAN NOT "CURRENT" IN PREVIOUS ROUND, GO TO HI25. IF THIS PLAN "CURRENT," AND THIS ROUND SUPPLEMENTAL SAMPLE ADDED, GO TO HI22a. OTHERWISE, GO TO ***BOX HI16A***.

HI22. [(Are you/Is SP) now covered by (PLAN NAME)?] [Was (SP) covered by (PLAN NAME) on (DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)?]

COVNOW	YES	1	***BOX HI16***
	NO	2	(HI24)
	REFUSED	-7	***BOX HI16***
	DON'T KNOW	-8	***BOX HI16***

BOX HI16	IF THIS PLAN NOT "CURRENT" IN PREVIOUS ROUND AND HI22 = 1, GO TO HI23. IF THIS PLAN NOT "CURRENT" IN PREVIOUS ROUND AND HI22 = REF OR DK, GO TO HI25. IF THIS PLAN "CURRENT" AND THIS ROUND SUPPLEMENTAL SAMPLE ADDED, GO TO HI22a. OTHERWISE, GO TO ***BOX HI16A***.

HI22a. Who (is/was) listed as the main insured person on the (PLAN NAME) policy or contract?
[ENTER ONLY ONE PERSON.]
MIPNUM
PLMIPNUM

HI22b. For the (PLAN NAME) plan, did (you/MIP) sign up directly, or did (you/MIP) get this insurance through a current employer, a former employer, a union, a family business, AARP, or some other way?

PRVGET	DIRECTLY	1	(HI22b1)
PPRVGET	(MIP'S) CURRENT EMPLOYER	2	(HI22c)
	(MIP'S) FORMER EMPLOYER	3	(HI22c)
	(MIP'S) UNION	4	(HI22d)
	(MIP'S) FAMILY BUSINESS	5	(HI22b1)
	AARP	6	(HI22b1)
	DECEASED SPOUSE'S EMPLOYER	7	(HI22c)
	DECEASED SPOUSE'S UNION	8	(HI22d)
	PROFESSIONAL/FRATERNAL ORGANIZATION	9	(HI22d)
	SOME OTHER WAY (SPECIFY) _____	91	(HI22d)
PRVGETOS	REFUSED	-7	(HI22d)
PPRVGTOS	DON'T KNOW	-8	(HI22d)

HI22b1. Many Medicare Supplemental or Medigap plans are referred to by a plan letter. There are ten standardized policies, labeled **Plan "A" through Plan "J"**. (Does/Did) (your/MIP's) (PLAN NAME) have a plan letter?

PRVLETR	YES	1	(HI22b2)
	NO	2	***BOX HI16AA***
	REFUSED	-7	***BOX HI16AA***
	DON'T KNOW	-8	***BOX HI16AA***

HI22b2. What (is/was) the plan letter for (your/MIP's) (PLAN NAME)?

PLANLETR PLAN LETTER _____

BOX HI16AA	IF HI22b = 5, GO TO HI22c. OTHERWISE, GO TO HI22d.

HI22c. What kind of business or industry is (RESPONSE IN HI22b)? That is, what does (RESPONSE IN HI22b) make or do? [RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

PRVBUS1	_____	**PPRVBUS1**
PRVBUS2		**PPRVBUS2**
PRVBUS3	_____	**PPRVBUS3**
INDCODE		**PINDCODE**
	_____	

HI22d. How many family members, including (yourself/SP), (are/were) covered by (your/MIP's) (PLAN NAME)?

PRVNMCOV NUMBER COVERED _____

HI22e. (Does/Did) (your/MIP's) (PLAN NAME) plan cover medicines prescribed by a doctor?

PRVRXCOV

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HI16A1	IF PLAN IS A MANAGED CARE PLAN, GO TO HI22e1. OTHERWISE, GO TO HI22f.

HI22e1. [Do you/Does (SP)/Did (SP)] have dental coverage through (PLAN NAME)?

MHMODENT

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HI22e2. [Do you/Does (SP)/Did (SP)] have optical coverage through (PLAN NAME), that is, for eyeglasses or contact lenses?

MHMOEYE

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HI22e3. [Do you/Does (SP)/Did (SP)] have coverage for preventive care such as routine annual physicals through (PLAN NAME)?

MHMOPCAR	YES	1	
	NO	2	
	REFUSED	-7	
	DON'T KNOW	-8	

HI22f. Would (your/MIP's) (PLAN NAME) plan (cover/have covered) any part of a stay in a nursing home?

PRVNHCOV	YES	1	
	NO	2	
	REFUSED	-7	
	DON'T KNOW	-8	

HI22g. [Do you/Does (MIP)/Did (SP)/Did (MIP)] pay any or all of the premium or cost for the (PLAN NAME) coverage? [Do not include the cost of any deductibles (you/SP) or (your/SP's) family may (have/have had) to pay.]

MIPPINS	YES	1	(HI22h)
	NO	2	(HI22h1)
	REFUSED	-7	(HI22h1)
	DON'T KNOW	-8	(HI22h1)

HI22h. How much [(do you/does (MIP)/did (SP)/did (MIP)] pay for the (PLAN NAME) coverage?
[PROBE IF NECESSARY: (Is/Was) that per year, per month, per week, or what?]

	AMOUNT: $_____.____		
MIPPAMT	PER YEAR	1	
	QUARTERLY/EVERY 3 MONTHS	2	
	BIMONTHLY/EVERY 2 MONTHS	3	
	PER MONTH	4	
	PER WEEK	5	
MIPPUNIT	SEMI-ANNUALLY/2 TIMES PER YEAR	6	
MIPPUNOS	SEMI-MONTHLY/2 TIMES PER MONTH	7	
	OTHER (SPECIFY) _____	91	
	REFUSED	-7	
	DON'T KNOW	-8	

HI22h1. Does anyone else, such as an employer, a union or professional organization pay all or some portion of the premium or cost for (your/MIP's) (PLAN NAME) coverage?

MHMOCOST	YES	1	(HI22h2)
	NO	2	***BOX HI16A2***
	REFUSED	-7	***BOX HI16A2***
	DON'T KNOW	-8	***BOX HI16A2***

HI22h2. Who else pays all or some portion of the cost for (your/MIP's) (PLAN NAME) coverage?

MHMOWHO	(MIP's) CURRENT EMPLOYER	1
	(MIP's) FORMER EMPLOYER	2
	(MIP's) UNION	3
	SPOUSE'S CURRENT EMPLOYER	4
	SPOUSE'S FORMER EMPLOYER	5
	PROFESSIONAL/FRATERNAL ORGANIZATION	6
	MEDICAID/MEDICAL ASSISTANCE	7
MHMOWHOS	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

BOX HI16A2	IF PLAN IS A MANAGED CARE PLAN, GO TO HI22h3. OTHERWISE, GO TO ***BOX HI16A***.

HI22h3. Some managed care plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. [Are you/Is (SP)/Was (SP)] enrolled in a point-of-service option offered by (PLAN NAME)?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a $10 copayment. However, the member may have to pay 20 percent of the cost and the plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

MHMOPOS	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

BOX HI16A	GO TO HI21 FOR NEXT PREVIOUS ROUND PRIVATE PLAN OR GO TO HI17 TO COLLECT NEW PRIVATE PLANS FOR THIS ROUND.

HI23. On what date did (your/SP's) coverage under (PLAN NAME) start between (REF. DATE) and (today/DATE OF DEATH/DATE OF INSTITUTIONALIZATION)?

COVBEGMM **COVBEGDD** **COVBEGYY** _____/_____/_____ (HI25)
MM DD YY

HI24. On what date since [(REF. DATE)/between (PREVIOUS ROUND INTERVIEW DATE) and (DATE OF DEATH/ DATE OF INSTITUTIONALIZATION)] did (your/SP's) coverage under (PLAN NAME) stop?

COVENDMM **COVENDDD** **COVENDYY** _____/_____/_____
MM DD YY

BOX HI17	IF HI24 BEING ASKED FOR PRIVATE PLAN FROM PREVIOUS ROUND, GO TO HI21 FOR NEXT PRIVATE PLAN FROM PREVIOUS ROUND. IF NO MORE PRIVATE PLANS FROM PREVIOUS ROUND, GO TO HI17 TO COLLECT ANY NEW PRIVATE PLANS FOR THIS ROUND. IF HI24 BEING ASKED FOR PRIVATE PLAN COVERAGE FOR THIS ROUND, GO TO HI25.

HI25. [CODE WITHOUT ASKING IF VOLUNTEERED.]
(Is/Was) this a managed care plan, such as an HMO (Health Maintenance Organization)?
[EXPLAIN IF NECESSARY: Managed care plans generally provide a full range of health care services for a prepaid fee. The major types of managed care plans are health maintenance organizations (HMOs), HMOs with a point-of-service option, Provider-Sponsored Organizations (PSOs), and Preferred Provider Organizations (PPOs).]

D_HMOPL1	YES	1	
D_HMOPL2	NO	2	
D_HMOPL3	REFUSED	-7	
D_HMOPL4	DON'T KNOW	-8	
D_HMOPL5			

HI26. Who (is/was) listed as the main insured person on the (PLAN NAME) policy or contract?
[ENTER ONLY ONE PERSON.]
PLMIPNUM
MIPNUM

HI27. For the (PLAN NAME) plan, did (you/MIP) sign up directly, or did (you/MIP) get this insurance through a current employer, a former employer, a union, a family business, AARP, or some other way?

PRVGET	DIRECTLY	1	(HI27a)
PPRVGET	(MIP'S) CURRENT EMPLOYER	2	(HI28)
	(MIP'S) FORMER EMPLOYER	3	(HI28)
	(MIP'S) UNION	4	(HI29)
	(MIP'S) FAMILY BUSINESS	5	(HI27a)
	AARP	6	(HI27a)
	DECEASED SPOUSE'S EMPLOYER	7	(HI28)
	DECEASED SPOUSE'S UNION	8	(HI29)
	PROFESSIONAL/FRATERNAL ORGANIZATION	9	(HI29)
	SOME OTHER WAY (SPECIFY) _____	91	(HI29)
PRVGETOS	REFUSED	-7	(HI29)
PPRVGTOS	DON'T KNOW	-8	(HI29)

HI27a. Many Medicare Supplemental or Medigap plans are referred to by a plan letter. There are ten standardized policies, labeled **Plan "A" through Plan "J"**. (Does/Did) (your/MIP's) (PLAN NAME) have a plan letter?

PRVLETR	YES	1	(HI27b)
	NO	2	***BOX HI17AA***
	REFUSED	-7	***BOX HI17AA***
	DON'T KNOW	-8	***BOX HI17AA***

HI27b. What (is/was) the plan letter for (your/MIP's) (PLAN NAME)?

PLANLETR PLAN LETTER _____

BOX HI17AA	IF HI27 = 5, GO TO HI28. OTHERWISE, GO TO HI29.

HI28. What kind of business or industry is (RESPONSE IN HI27)? That is, what does (RESPONSE IN HI27) make or do? [RECORD VERBATIM. PRESS ENTER TO LEAVE SCREEN.]

PRVBUS1	_____	**PPRVBUS1**
PRVBUS2	_____	**PPRVBUS2**
PRVBUS3	_____	**PPRVBUS3**
INDCODE	_____	**PINDCODE**
	_____	

HI29. How many family members, including (yourself/SP), (are/were) covered by (your/MIP's) (PLAN NAME)?

PRVNMCOV NUMBER COVERED _____

HI30. (Does/Did) (your/MIP's) (PLAN NAME) plan cover medicines prescribed by a doctor?

PRVRXCOV	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

BOX HI17A	IF PLAN IS A MANAGED CARE PLAN (HI25 = 1), GO TO HI30a. OTHERWISE, GO TO HI31.

HI30a. (Do/Does/Did) (you/SP) have dental coverage through (PLAN NAME)?

MHMODENT	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

HI30b. (Do/Does/Did) (you/SP) have optical coverage through (PLAN NAME), that is, for eyeglasses or contact lenses?

MHMOEYE

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HI30c. (Do/Does/Did) (you/SP) have coverage for preventive care such as routine annual physicals through (PLAN NAME)?

MHMOPCAR

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HI31. Would (your/MIP's) (PLAN NAME) plan (cover/have covered) any part of a stay in a nursing home?

PRVNHCOV

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

HI32. [Do you/Does (MIP)/Did (you/MIP)/Did (MIP)] pay any or all of the premium or cost for the (PLAN NAME) coverage?
[Do not include the cost of any deductibles (you/SP) or (your/SP's) family may (have/have had) to pay.]

MIPPINS

YES	1	(HI33)
NO	2	(HI33a)
REFUSED	-7	(HI33a)
DON'T KNOW	-8	(HI33a)

BOX HI18 OMITTED IN R20.

HI33. How much [do you/does (MIP)/did (you/MIP)/did (MIP)] pay for the (PLAN NAME) coverage?
[PROBE IF NECESSARY: (Is/Was) that per year, per month, per week, or what?]

AMOUNT $_____.____

MIPPAMT

PER YEAR	1
QUARTERLY/EVERY 3 MONTHS	2
BIMONTHLY/EVERY 2 MONTHS	3
PER MONTH	4
PER WEEK	5

MIPPUNIT

SEMI-ANNUALLY/2 TIMES PER YEAR	6
SEMI-MONTHLY/2 TIMES PER MONTH	7

MIPPUNOS

OTHER (SPECIFY) _____	91
REFUSED	-7
DON'T KNOW	-8

HI33a. (Does/Did) anyone else, such as an employer, a union or professional organization pay all or some portion of the premium or cost for (your/MIP's) (PLAN NAME) coverage?

MHMOCOST	YES	1	(HI33b)
	NO	2	***BOX HI17B***
	REFUSED	-7	***BOX HI17B***
	DON'T KNOW	-8	***BOX HI17B***

HI33b. Who else (pays/paid) all or some portion of the cost for (your/MIP's) (PLAN NAME) coverage?

MHMOWHO	(MIP's) CURRENT EMPLOYER	1
	(MIP's) FORMER EMPLOYER	2
	(MIP's) UNION	3
	SPOUSE'S CURRENT EMPLOYER	4
	SPOUSE'S FORMER EMPLOYER	5
	PROFESSIONAL/FRATERNAL ORGANIZATION	6
	MEDICAID/MEDICAL ASSISTANCE	7
MHMOWHOS	OTHER (SPECIFY) _____	91
	REFUSED	-7
	DON'T KNOW	-8

BOX HI17B	IF PLAN IS A MANAGED CARE PLAN, GO TO HI33c. OTHERWISE, GO TO ***BOX HI19***.

HI33c. Some managed care plans offer a point-of-service option which allows members to receive services from out-of-plan providers even in non-emergency situations. [Are you/Were you/Is (SP)/Was (SP)] enrolled in a point-of-service option offered by (PLAN NAME)?

[EXPLAIN IF NECESSARY: In a point-of-service option, the member typically pays a higher copayment when seeing an out-of-plan provider. For example, if a member sees an in-plan provider, there may only be a $10 copayment. However, the member may have to pay 20 percent of the cost and the managed care plan will pay 80 percent of the cost to receive the same service from an out-of-plan provider.]

MHMOPOS	YES	1
	NO	2
	REFUSED	-7
	DON'T KNOW	-8

BOX HI19	CYCLE THROUGH QUESTIONS HI21-HI33c FOR EACH PRIVATE PLAN REPORTED IN HI20. IF HI34=1 IN PREVIOUS ROUND OR IF HI34=1 or 2 OR MISSING FOR THIS ROUND, GO TO HI35. IF HI34=2 OR MISSING (REF, DK, -9) IN PREVIOUS ROUND OR -1 (INAPPLICABLE) FOR THIS ROUND, GO TO HI34.

HI34. (Other than the plans you have already told me about,) (do you/does SP/did SP) have any insurance that (pays/paid) **just** for **nursing home** care or other long term care?

OTHNHCOV

YES	1	(HI20)
NO	2	(HI35)
REFUSED	-7	(HI35)
DON'T KNOW	-8	(HI35)

HI35. We've talked about [READ PLANS LISTED BELOW]. (Do you/Does SP/Did SP) have medical coverage under any (other) private insurance plans we haven't talked about?

PRVOCOV

YES	1	(HI20)
NO	2	***BOX HI20***
REFUSED	-7	***BOX HI20***
DON'T KNOW	-8	***BOX HI20***

BOX HI20	IF SP SERVED IN THE ARMED FORCES (I.E., EN9 OR EN11=1) AND HI36 = 2, REF, DK, OR -9 IN PREVIOUS ROUND, OR THIS IS FIRST UTILIZATION INTERVIEW FOR SP, GO TO HI36. IF SP DID NOT SERVE IN THE ARMED FORCES (I.E., EN9 AND EN11=2, REF, DK, OR -9) OR SP SERVED IN THE ARMED FORCES AND HI36 = 1 IN PREVIOUS ROUND, OR SP SERVED IN ARMED FORCES AND THIS IS FIRST COMMUNITY INTERVIEW, GO TO ***BOX HI21A***.

HI36. We recorded that (you/SP) served in the Armed Forces of the United States. Since (REF. DATE), [(have you/has SP) received/did (SP) receive] health care or health services or prescribed medicines through the Department of Veterans Affairs or V.A.?

VACOVER

YES	1
NO	2
REFUSED	-7
DON'T KNOW	-8

BOX HI21 OMITTED IN ROUND 33.

BOX HI21A	GO TO ***BOX DM1***.

ATTACHMENT HI1

STATE MEDICAID PROGRAMS

STATE	**PROGRAM NAME**
Alaska (AK)	Medical Assistance
Alabama (AL)	Medicaid
Arkansas (AR)	Medical Services
Arizona (AZ)	Health Care Cost Containment System (AHCCCS)
California (CA)	Medi-Cal
Colorado (CO)	Medicaid
Connecticut (CT)	Medical Assistance
District of Columbia (DC)	Medical Assistance
Delaware (DE)	Medical Services
Florida (FL)	Medicaid
Georgia (GA)	Medical Assistance
Hawaii (HI)	Medical Assistance
Iowa (IA)	Medical Services
Idaho (ID)	Medicaid
Illinois (IL)	Medicaid
Indiana (IN)	Medicaid
Kansas (KS)	Medical Assistance, Title XIX or MediKan
Kentucky (KY)	Medicaid
Louisiana (LA)	Medicaid
Maine (ME)	Medical Services or PrimeCare
Massachusetts (MA)	MassHealth or Medical Assistance
Maryland (MD)	Medical Assistance
Michigan (MI)	Medical Assistance
Minnesota (MN)	Medical Assistance
Missouri (MO)	Medical Services
Mississippi (MS)	Medicaid
Montana (MT)	Medicaid
North Carolina (NC)	Medical Assistance

ATTACHMENT HI1 (continued)

STATE MEDICAID PROGRAMS

STATE	**PROGRAM NAME**
North Dakota (ND)	Medical Services
Nebraska (NE)	Medical Assistance
New Hampshire (NH)	Medicaid
New Jersey (NJ)	Medicaid
New Mexico (NM)	Medical Assistance
Nevada (NV)	Medicaid
New York (NY)	Medicaid
Ohio (OH)	Medicaid
Oklahoma (OK)	Medicaid
Oregon (OR)	Medical Assistance
Pennsylvania (PA)	Medical Assistance
Puerto Rico (PR)	Medical Assistance
Rhode Island (RI)	Medical Assistance
South Carolina (SC)	Medicaid
South Dakota (SD)	Medical Services
Tennessee (TN)	TennCare
Texas (TX)	Medicaid
Utah (UT)	Medicaid
Vermont (VT)	Medicaid
Virginia (VA)	Medical Assistance
Washington (WA)	Medical Assistance
Wisconsin (WI)	Medical Assistance
West Virginia (WV)	Medical Services
Wyoming (WY)	Title 19

ATTACHMENT HI2

STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
California Discount Prescription Medication Program	Department of Health Services	California	(916) 657-4302 HICAP: (800) 434-0222
CT Pharmaceutical Assistance Contract to the Elderly and Disabled Prog. (ConnPACE)	Connecticut Dept. of Social Services P.O. Box 5011	Hartford, CT 06102	(860) 832-9265 (800) 423-5026
Delaware Prescription Drug Payment Assistance Program (DPAP)	Division of Social Services EDS DPAP P.O. Box 950	New Castle, DE 19720-9914	(800) 996-9969, x 17 (302) 577-4900
Delaware Nemours Health Clinic Pharmaceutical Assistance Program	1801 Rockland Road	Wilmington, DE 19803	(302) 651-4405 (800) 292-9538
Florida Discount Prescription Program	Agency for Health Care Administration 2727 Mahan Dr.	Tallahassee, FL 32308	(850) 487-4441 (888) 419-3456
Florida Prescription Affordability Act	Agency for Health Care Administration	Tallahassee, FL 32999	(800) 963-5337 (888) 419-3456 (850) 414-8306
Illinois Pharmaceutical Assistance Program	Dept. of Revenue P.O. Box 19021	Springfield, IL 62794	(217) 524-0084, x 32347 (800) 624-2459
Indiana Prescription Drug Fund (Hoosier Rx)	P.O. Box 6224	Indianapolis, IN 46206-6224	(317) 234-1381 (866) 267-4679
Iowa Priority Prescription Savings Program	Dept. of Public Health 1231 8th St. Suite 232	West DesMoines, IA 50265	(515) 281-4343 (866) 282-5817
Kansas Senior Pharmacy Assistance Program	Dept. of Aging	Kansas	(785) 368-7327
Healthy Maine Prescription Program	Department of Human Services 13 Prescott Drive	Machias, ME 04654	(888) 600-2466 (207) 287-2674
Maryland Pharmacy Assistance Program (MPAP)	Secretary of Health and Mental Hygiene P.O. Box 386	Baltimore, MD 21203	(410) 767-5394 (800) 492-1974
Maryland Care First Plan/Short-Term Prescription Drug Subsidy Program	Secretary of Health and Mental Hygiene P.O. Box 386	Baltimore, MD 21203	(410) 767-5394 (800) 492-1974
Massachusetts Prescription Advantage Plan	Exec. Office of Elder Affairs 1 Ashburton Place	Boston, MA 02108	(800) 243-4636 (617) 727-7750

ATTACHMENT HI2 (continued)

STATE PHARMACEUTICAL PROGRAMS

NAME	ADDRESS	CITY, STATE	PHONE
Michigan Elder Prescription Insurance Coverage (EPIC) Program	Dept. of Community Health, Lewis Cass Bldg., 6th Fl., 320 South Walnut St.	Lansing, MI 48913	(517) 373-2559 (866) 747-5844
Minnesota Prescription Drug Program	Minnesota Department of Human Services 444 Lafayette Rd. North	Saint Paul, MN 55155	(651) 297-5404 (800) 333-2433
Nevada Senior Rx Insurance Subsidy for Prescription Drugs	Aging Services Division, 3416 Goni Rd, Bldg. D, Suite 132	Carson City, NV 89710	(775) 684-4000 (800) 262-7726
New Jersey Pharmaceutical Assistance for the Aged and Disabled (PAAD)	Department of Health and Senior Services	Trenton, NJ 08625	(609) 588-7048 In NJ: (800) 792-9745
New Jersey Senior Gold Prescription Drug Discount	Department of Health and Senior Services	Trenton, NJ 08625	(609) 588-7048 (800) 792-9745
New York State Elderly Pharmaceutical Insurance Coverage (EPIC)	P.O. Box 15018	Albany, NY 12212-5018	(518) 452-6828 In NY: (800) 332-3742
North Carolina Prescription Drug Assistance Program	Public Health Dept.	Raleigh, NC 27699	(919) 715-3338 (800) 662-7030
Pennsylvania Pharmacy Assistance Contract for the Elderly (PACE)	P.A. Dept. of Aging 555 Walnut St. 5th Floor	Harrisburg, PA 17101	(717) 652-9028, In PA: (800) 225-7223
Pennsylvania PACE Needs Enhancement Tier (PACENET)	P.A. Dept. of Aging 555 Walnut St. 5th Floor	Harrisburg, PA 17101	(717) 652-9028, In PA: (800) 225-7223
Rhode Island Pharmaceutical Assistance for the Elderly (RIPAE)	Dept. of Elderly Affairs 160 Pine Street	Providence, RI 02903	(401) 222-2880 (800) 222-2880
South Carolina SilverXCard – Seniors' Prescription Drug Program	Office of Insurance Services		(877) 239-5277 (803) 734-1061
Vermont Health Access Program (VHAP)	103 S. Main Street	Waterbury, VT 05671	(800) 529-4060 (800) 250-8427
VT State Pharmaceutical Assistance Prog. for Elderly & Disabled (VSCRIPT)/VSCRIPT Expanded	103 S. Main Street	Waterbury, VT 05671	(800) 529-4060 (800) 250-8427
Wyoming Minimum Medical Program	Healthcare Access and Resources Division, Hathaway Bldg, Rm. 154	Cheyenne, WY 82002	(307) 777-7531 (800) 442-2766

ATTACHMENT HI3

STATES THAT DO NOT HAVE MEDICARE HMOs

AK
AR
ME
MT
SC
UT
VT
WY